



# South Carolina Department of Insurance

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## BULLETIN NUMBER 2013-01

**TO:** All Insurers Licensed to Transact Accident and Health Insurance Business within the State of South Carolina and All South Carolina Licensed Health Maintenance Organizations (collectively "Health Insurance Issuers")

**FROM:** Raymond G. Farmer  
Director of Insurance *R.G.F.*

**SUBJECT:** Rate Filing Procedures for Health Insurance Rate Change Requests, Rate Filing Procedures for New Products, and Other Rating Factors

**DATE:** April 5, 2013

### I. PURPOSE

South Carolina has previously been deemed an effective rate review state. Accordingly, the South Carolina Department of Insurance (Department) plans to continue its traditional regulatory role of reviewing insurance rates and forms for the protection of South Carolina consumers. This Bulletin establishes requirements for Health Insurance Issuers offering Health Insurance Coverage in the small group or Individual Markets, to report information on rate changes both those that are above a specific threshold and designated as subject to review and those that are below the threshold. This Bulletin also establishes the process by which such rate changes are reviewed to determine whether they are unreasonable.

Further, in the last few years, numerous new requirements and limitations have been placed on health insurance products, in general, and those health insurance products that can be sold beginning on January 1, 2014. This Bulletin establishes the process by which the rates for new products filed on or after April 1, 2013 are reviewed to determine whether they are unreasonable.

For purposes of this Bulletin, the terms "Health Insurance Issuer" or "Issuer," "Health Insurance Coverage," "Small Group Market," and "Individual Market" shall have the meaning set forth in §38-71-670 and §38-71-840 (2002). The Department is requiring additional information in accordance with the Director's authority under §38-13-160, §38-71-310(B), §38-71-750, and

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§38-71-970(C). The requirements in this bulletin also apply to multi-state and co-op plans transacting business within this state.

This Bulletin also provides information related to other rating factors and reaffirms the minimum county geographical rating areas previously established under South Carolina law. Rating areas are separate and distinct from service areas. Service areas are the geographic regions in which an insurer elects to operate. Rating areas are the geographic areas established for varying premium costs. Rating areas apply to all non-grandfathered small group and individual plans and must be applied consistently in the health insurance market.

## II. APPLICABILITY AND SCOPE

Health Insurance Issuers offering health insurance in the individual and Small Group Markets must comply with these new requirements. All plans must continue to comply with existing filing requirements which may be found on the Department's website, [www.doi.sc.gov](http://www.doi.sc.gov). This Bulletin is not applicable to grandfathered health insurance plans or excepted benefits.

This Bulletin addresses requirements for the individual, small group and association markets. Those terms have the meaning set forth below:

*Individual Market* has the meaning set forth in 38-71-670(11). Coverage that would be regulated as Individual Market coverage if it were not sold through an association is subject to rate review as Individual Market coverage.

*Small Group Market* has the meaning set forth under section 38-71-840(29). Coverage that would be regulated as Small Group Market coverage if it were not sold through an association is subject to rate review as Small Group Market coverage.

*Association coverage* includes coverage issued to a trust or to insure persons who are associated in a common group for purposes other than obtaining insurance e.g., employee sponsored plans. It also includes coverage extended to residents of this State under a policy issued outside of South Carolina.

Health Insurance Issuers are required to report certain information for rate increases for existing products that are above a specific threshold ("additional reporting requirements") and information for rate increases that are below the rate threshold. South Carolina law provides that the Director may require special reports on any matter necessary for the administration of the laws of this state. Accordingly, the Department is requiring submission of the additional reporting requirements for all rate changes for Health Insurance Coverage in the Individual and Small Group Markets. This additional information will enhance the Director's or his designee's ability to determine whether a health insurance rate is unreasonable in accordance with the requirement of §38-71-310 and §38-71-920 through §38-71-970.

In addition, for a new product filed on or after April 1, 2013, the Department is requiring the

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submission of certain required information so that the Director, or the Director's designee, can determine whether the rate on any new product is unreasonable in accordance with the requirement of §38-71-310 and §38-71-920 through §38-71-970.

### **III. ADDITIONAL REPORTING REQUIREMENTS**

Each Health Insurance Issuer shall file with the Department every proposed premium rate change to be used in connection with a particular product in the Individual or Small Group Markets.

If any product is subject to a rate change, a Health Insurance Issuer must submit a Rate Filing Justification for all products in the single risk pool, including new or discontinuing products.

When referring to the section, a rate change for this section occurs whenever there are:

- a. Changes to the new business premium rate;
- b. Changes to a rating factor;
- c. Changes to a rate calculation methodology;
- d. Changes in benefits; and
- e. Changes to trend or other rating assumptions.

Coverage that would be regulated as individual or small employer group coverage if it were not sold through an association is subject to the requirements of this Bulletin even if the policy was issued out-of-state.

With each submission of a proposed rate change or to the Department, in addition to the current filing requirements, all Health Insurance Issuers shall submit the following information:

- 1) Unified Rate Review Template (Part I), should be submitted in the standard Excel format provided. The filing must include the following information:
  - a. Historical and projected claims experience;
  - b. Trend projections related to utilization and service or unit cost;
  - c. Any claims assumptions related to benefit changes;
  - d. Allocation of the overall rate increase to claims and non-claims costs;
  - e. Per enrollee per month allocation of current and projected premium; and
  - f. Three-year history of rate increases for the product associated with the rate increase.
- 2) Written Description Justifying the Rate Change (Part II) which must include a simple and brief narrative describing the data and assumptions used to develop the rate change, including the following:

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- a. An explanation of the most significant factors causing the rate change, including a brief description of the relevant claims and non-claims expense changes reported in the rate change summary; and
- b. A brief description of the overall experience of the policy, including historical and projected expenses and loss ratios.

3) Rate Filing Documentation (Part III) including:

An actuarial memorandum that contains the reasoning and assumptions supporting the data contained in the Rate Filing Justification which must be sufficient to conduct an examination satisfying the requirements set forth in the remainder of this Bulletin and to determine if the proposed rate increase is an unreasonable increase.

With each submission to the Department of a proposed rate for a new product filed on or after April 1, 2013, in addition to the current filing requirements, all Health Insurance Issuers shall submit the following information:

- 1) Unified Rate Review Template (Part I), as described above. The Unified Rate Review Template should be submitted in the standard Excel format; and
- 2) Rate Filing Documentation (Part III). The actuarial memorandum should be in the standard format described above and should include sufficient information to demonstrate that the proposed new rates comply with the rating requirements of the 2014 market reforms and for the Department to determine if the proposed rates are unreasonable.

#### **IV. REVIEW OF ADDITIONAL REPORTING REQUIREMENTS**

The Department will use this additional information to evaluate the proposed rate change or proposed rate for a new product to make a determination as to whether it is unreasonable in accordance with the standards set forth in §38-71-310(B) for the Individual Market and §38-71-970 for the Small Group Market.

The Department shall consider the proposed rates unreasonable if the proposed rates are:

- 1) Inadequate; or
- 2) Excessive; or
- 3) Unfairly discriminatory; or
- 4) Unjustified; or
- 5) Not compliant with applicable federal laws or all state laws, regulations, and bulletins.

The evaluation will include, but will not be limited to, an examination of the following:

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- 1) The reasonableness of the assumptions used by the Health Insurance Issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions;
- 2) The Health Insurance Issuer's data related to past projections and actual experience;
- 3) The reasonableness of assumptions used by an Issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections;
- 4) The Health Insurance Issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial value, and other market reform rules as required, including confirmation that:
  - a. plan-specific adjustments to the market-wide index rate do not reflect differences in health status or risk selection;
  - b. the premium rate for any given plan does not vary from the resulting adjusted market-wide index rate, except for the following factors: the actuarial value and cost-sharing structure of the plan; the plan's provider network, delivery system characteristics, and utilization management practices, plan benefits in addition to EHB; and
  - c. only allowed rating variables have been used; and
- 5) Attestation statements regarding the metallic tier for each plan.

In reviewing all rate filings under this Bulletin, the Department may take into consideration the following criteria, to the extent applicable, to determine if the filing is unreasonable:

- The impact of medical trend changes by major service categories;
- The impact of utilization changes by major service categories;
- The impact of cost-sharing changes by major service categories, including actuarial values;
- The impact of benefit changes, including essential health benefits and non-essential health benefits;
- The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under Section 2701 of the Public Health Service Act;
- The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase;
- The impact of changes in reserve needs;
- The impact of changes in administrative costs related to programs that improve health care quality;
- The impact of changes in other administrative costs;
- The impact of changes in applicable taxes, licensing, or regulatory fees;
- The medical loss ratio, including the adjusted loss ratio, subject to the requirements of federal statute, regulation, or rule;
- The financial performance of the Issuer including capital and surplus;
- The impacts of geographic factors and variations;

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- The impact of changes within a single risk pool to all products or plans within the risk pool;
- The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the ACA;
- The impact of offering a Catastrophic Plan;
- The impact of offering family policies; and
- Consumer comments regarding the rate filing.

Health Insurance Issuers must submit any additional information required by the Department in conducting these reviews.

For any rate increase that meets or exceeds the review threshold, the Department shall, upon request by Health and Human Services (HHS), provide its final determination with respect to unreasonableness along with a brief explanation of the final determination.

The Department will provide a link on its website to certain information that the Centers for Medicare and Medicaid Services (CMS) makes available to the public. Further, the Department has established a dedicated electronic mailbox as a mechanism for receiving public comments on those proposed rate increases.

## **VI. OTHER RATING FACTORS**

States have submitted certain rating information to CMS generally to support the accuracy of the risk adjustment methodology. This includes information about the following, as applicable:

- The use of an age rating ratio narrower than 3:1 for adults age 21 and older;
- The use of a tobacco rating ratio narrower than 1.5:1 for individuals who legally use tobacco;
- The actual state-established or proposed rating areas;
- State-established age rating curves;
- In states with community rating, the use of uniform family tiers and corresponding multipliers;
- A requirement that premiums be based on average enrollee amounts in the Small Group Market; and
- States' decisions about whether to merge the individual and Small Group Markets in a state into a single risk pool.

South Carolina does not plan to submit narrower age or tobacco rating ratios nor does South Carolina have community rating. Accordingly, insurers transacting health insurance business in this shall use the age and tobacco ratios as well as the age-rating curves, family tiers, and corresponding multipliers set forth in the final rule. Similarly, South Carolina will not require

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that premiums be based on average enrollee amounts in the Small Group Market and South Carolina will not merge the individual and Small Group Markets into a single risk pool.

As to geographic rating areas, a county shall continue being the minimum geographical rating area in South Carolina. South Carolina has permitted geographic rating based on county since 1994 for the Small Group Market and 1992 for the individual health insurance market. South Carolina law provides as follows:

“Nothing contained in this section may be construed to prevent the use of age, sex, **area**, industry, occupational, and avocational factors or to prevent the use of different rates for smokers and nonsmokers or for any other habit or habits of an insured person which have a statistically proven effect on the health of the person and are approved by the director or his designee. Also, nothing contained in this section shall preclude the establishment of a substandard classification based upon the health condition of the insured, but the initial classification may not be changed adversely to the applicant after initial issue.” *See S.C. Code Ann. § 38-71-325 (2002).*

An insurer was not permitted to underwrite in an area smaller than a county without the prior approval of the Department. The county basis for rating was further codified by the South Carolina legislature in 1997 via the South Carolina small group rating laws.

South Carolina Code Section 38-71-920 provides as follows:

(5) "Case characteristics" means the following characteristics of a small employer, as determined by a small employer insurer, which are considered by the insurer in the determination of premium rates for the small employer: age, gender, **geographic area**, industry, group size, and family composition. **Geographic areas smaller than a county may not be used without prior approval of the director or his designee.** Claim experience, health status, and duration of coverage since issue are not case characteristics for the purposes of this sub-article. The adjustment for case characteristics must be objective and meet sound actuarial practices.

The Department has not permitted a geographic area smaller than a county since the 1990's. Accordingly, the state established by **law and related executive action** minimum geographic rating areas for the entire state equal to a county. South Carolina, therefore, defines the minimum uniform rating areas by county. Each of South Carolina's forty-six counties is established as a separate and distinct rating area for rating purposes.

Preserving the geographic rating area based on county is consistent with applicable South Carolina law and prevailing industry practice. It will allow insurers to adjust premiums to reflect differences in the cost of medical care. South Carolina's consumers and health insurance market should experience the least disruption from maintaining this practice. Currently, most insurers vary their rates by county using the employer's business address in the Small Group Market and the policyholder's home address in the Individual Market.

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## **VII. FILING INFORMATION**

All filings and other submissions must be filed through the SERFF system. To assist insurers with the filing requirements set forth in this Bulletin, the Department shall make filing information available on its website ([www.doi.sc.gov](http://www.doi.sc.gov)):

All filings and other submissions must be filed through the SERFF system.

For association coverage, Health Insurance Issuers must provide the following information for each filing:

- An indication as to whether the coverage is “Open” or “Closed” for new enrollees;
- An indication as to whether the coverage is sold in the Individual Market or the Small Group Market;
- If the coverage is sold in both the Individual Market and the Small Group Market, then the filing should indicate that it is sold in both markets and be labeled as “Small Group”.

To assist insurers with the filing requirements set forth in this Bulletin, the Department will make filing information available on its website ([www.doi.sc.gov](http://www.doi.sc.gov)).

## **VIII. EFFECTIVE DATE**

The additional reporting requirements apply to any rate changes filed in South Carolina on or after April 1, 2013 and any rate filing for any new product filed after April 1, 2013. This Bulletin supplements Bulletins 2011-03 and 2011-11 as they pertain to the existing filing requirements. To the extent that the requirements in Bulletin 2011-03 and Bulletin 2011-11 conflict with the requirements of this Bulletin, this Bulletin shall control as of April 1, 2013. To allow the Department sufficient time for review, all filers should submit this information at least 90 days in advance of the anticipated rate increase effective date.

## **IX. QUESTIONS**

Questions regarding this Bulletin should be addressed to:

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